Report of the Secretary's Task Force on Child Fatality Reporting

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To: John M. Hamilton
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Executive Summary

The Child Fatality Reports Task Force, as appointed by John M. Hamilton, Secretary of the Indiana Family and Social Services Administration (FSSA), has reviewed the system used by the Indiana Division of Family and Children (DFC) to report child fatalities in the State of Indiana. In brief, the Task Force found that there were internal and external factors that contributed to the reporting discrepancies. Based on our systemic review, the Task Force recommends the following:

1. Initiate and support appropriate legislative, regulatory, and management actions to ensure that the interests of the children involved in the CPS system are first priority among all other interests.
2. Review, support, and follow through on feasible recommendations of the Child Fatality Review Task Force in its report titled "Keeping Kids Alive: Recommendations for Implementing a Statewide Systematic Review of Childhood Deaths" (April 2000).
3. Seek expanded funding from all available sources to develop and focus expertise in child fatality prevention.
4. Support legislation enacting a Commission on Abused and Neglected Children and Their Families.
5. Promote maximum accountability of those responsible for child welfare and child protection for fully and properly executing their duties.
6. Employ the Indiana Child Welfare Information System (ICWIS) as the sole official system for the DFC's child welfare information.
7. Modify ICWIS system capabilities.
8. Enhance systems for data entry by increasing the use of technology in the field and use dedicated or temporary personnel for data entry purposes.
9. Release fatality information at a specified time each year, with an advisory that figures may require adjustment for reopening of cases where children die after abuse or neglect is substantiated.
10. Strengthen and clarify the role of the central office Bureau of Family Protection and Preservation (BFPP) relative to the local offices.
11. Clarify relevant child welfare policies and procedures.
12. Enact specific monitoring requirements at local, regional, and central office levels.
13. Continue to improve child welfare training with substantial focus on the quality of information gathered and reported, management training, and substantive skills.
14. Establish regional bodies of expertise in child fatality investigations.
15. Examine DFC policies and practices regarding the release of child fatality information to ensure the widest possible disclosure within the bounds of law.
16. Promote greater public involvement in child protection and child fatality reporting.
17. Identify a lead state agency to tabulate and report all child fatalities, and establish systems interfaces between ICWIS and State Board of Health information systems.
18. Encourage medical, criminal justice, health, and other key authorities outside DFC to establish and support training, best practices, and conduct standards for their staffs which provide for zero tolerance of malfeasance or nonfeasance, and to fully meet their statutory obligations.

Background

In November 2002, nearing the conclusion of a year long investigation of the child welfare system, the *Indianapolis Star* newspaper discovered inconsistencies between the 1999-2001 reports of child deaths resulting from neglect or abuse released by the Division of Family and Children (DFC) and information contained in agency records, media accounts and other sources. In light of this revelation, the DFC reassessed the child fatality statistics and determined that in each of the covered years, the actual number of deaths was higher than originally reported. The *Indianapolis Star*'s articles on unreported deaths included child fatalities that were both known to and investigated by the DFC and child fatalities that were never reported to the agency. Although some child fatalities known to the agency were not reported in the statewide child fatality report, all such cases had been fully investigated by the DFC.

Task Force Mission

On December 3, 2002, Secretary Hamilton chartered the ten-member Child Fatality Reports Task Force to:

1. Review the way reports are collected, and;

2. Recommend permanent changes in the system to provide for consistent, accurate reporting on child fatality information;

The Task Force was to complete its mission in forty-five (45) days. In reviewing the facts and circumstances leading to inaccurate reports of child fatalities in Indiana during the covered period, it was quickly apparent that numerous and difficult challenges face the myriad stakeholders in the child welfare and protection services arena. This is applicable both in the State of Indiana and in many other states across the nation. Accordingly, examining all the contemporary issues affecting child welfare, and proffering recommendations for remedial action would likely be helpful to improving child welfare throughout Indiana. However, that charge is far beyond this Task Force's charter, and is infeasible in the timeframe allotted. Rather, such an endeavor is better suited to a longer-term entity like the proposed Indiana Commission on Abused and Neglected Children and Their Families. Instead, this Task Force looked primarily at Indiana's system for collecting and reporting information about child fatalities and how that system can be improved. Notwithstanding, this Task Force did touch on several broader recommendations for future study to improve child welfare practice in Indiana.

Our focus was divided into two distinct areas. First, we examined internal situations where child fatality information was known to the agency but not included in the agency's statewide tallies. Second, we looked at external situations where relevant child fatality information that should be known by the agency was not in fact known by the agency, but was known by other entities in the community. As a result, our recommendations are divided into three categories: (1) comprehensive recommendations

affecting changes both internal and external to the agency; (2) recommendations affecting matters primarily internal to the agency, and; (3) recommendations for change external to the agency or beyond the specific scope of this Task Force.

Task Force Members

- Michael Murray, Chair; Assistant Director, FSSA Division of Family and Children
- Sharon Pierce; President and CEO of the Villages
- Cathy Graham; Executive Director of IARCCA, an association for children and family services
- Andrea Marshall, Executive Director of Prevent Child Abuse Indiana, Inc.
- Gail Folaron, Ph.D., Associate Professor of Social Work, I.U. School of Social Work
- Char Burkett-Sims, DFC Deputy Director Bureau of Family Preservation and Protection
- Patricia Hall, FSSA Division of Technology Services
- Jane Bisbee, Director, Greene County Office of Family and Children
- John Barksdale, Director, Floyd County Office of Family and Children
- Steve Vaughn, DFC Northwest Regional Manager

Methods

The Task Force convened over the course of five formal and several additional informal meetings at the DFC Executive Conference Room in Indianapolis to examine the state's processes. It examined actual practices used by local Offices of Family and Children located throughout Indiana, the DFC's Central Office, and other entities with whom both offices interact in the routine course of performing their duties. The Task Force also surveyed the actual child welfare practices of other states as well as recommended best practices in child welfare. In addition to marshalling the substantive expertise and experience of its members, the Task Force also interviewed Family Case Managers who deliver child welfare and protection services in the field, child welfare supervisors, and current and former central office program directors, and consulted with professional sources outside of state government. Although some of our information applies to facts occurring outside the covered period, most of our examination pertains to investigation and reporting activities since 1999.

As noted above, the Task Force examined two categories of child deaths:

1. Those known to but not reported by the agency, and;

2. Those where relevant child fatality information was not known to the agency but was known to others.

We took this approach because child fatalities in the latter category were captured by the *Star* articles and are often within the common knowledge of various Indiana

communities, which have a legitimate interest in understanding their government agencies' activities and in receiving responsive services from government. In addition, we emphasized *relevant* child fatality information because not every instance in which a child dies falls within the purview of the DFC. Only child fatalities alleged to have been caused as a result of child abuse or neglect fall within the authority of the DFC. Deaths from illnesses and other accidental causes may not be within the authority of the DFC for child fatality and protection services purposes. For reasons discussed below, deaths in this latter category may also be within the current debate.

Historical and Factual Background

Overwhelmingly, the family case managers and child welfare professionals of the DFC and other entities are dedicated to protecting and addressing the needs of the state's vulnerable, abused, and neglected children. The Task Force uncovered no instances in which intentional conduct resulted in inaccurate child fatality reporting or inadequate response. Providing these professionals with the tools, training, and support required to effectively execute their roles is the shared responsibility of all Indiana citizens.

Indiana is not alone in the problems of quantifying, tracking, and reporting child welfare statistics, including child fatalities. Countless jurisdictions across the nation struggle with both the definition and the number of child fatalities. According to a recent Child Welfare League of America report,

> "[T]he child welfare field struggles to clarify the data and ultimately understand how to prevent these deaths. The data reflects differences in state child welfare systems, state laws, definitions, practices, policies and how data are collected and reported."

At least 40% of state child welfare agencies believe the number of child fatalities reported actually *understates* the problem of child abuse and neglect fatalities. Several factors emerged as primary reasons for the difficulty in obtaining accurate child fatality statistics:

1. No national standard definition exists to classify child abuse and neglect fatalities;
2. States are challenged by the lack of standard definitions and terminology across agencies…child welfare agency, law enforcement, medical examiner, public health agency…or across counties or regions;
3. The centralized data systems employed by states, which used the federal Statewide Automated Child Welfare Information System (SACWIS) funding, have difficulty recording deaths not *clearly* related to abuse or neglect. The impetus for SACWIS funding was to ensure each state would report Adoption and Foster Care Analysis and Reporting System (AFCARS) data in a consistent electronic format. Thus, many states do not record deaths in their centralized system unless it clearly meets the abuse and neglect definitions;
4. Delays in the child fatality review process may prevent states from reporting complete data;

5. Child abuse and neglect fatalities may not be counted when the child welfare agency is not notified of the death by another agency or mandated reporter, and;
6. Access to adequate funding and resources limits the child fatality review process and the accuracy of child fatality data in many states.

In Indiana, the child welfare system is structured with the policy-making function headquartered at the central office BFPP in Indianapolis, and the implementation function taking place at numerous offices in the state's 92 counties, divided into six (6) regions headed by regional managers. Administrative funding for local offices is provided by the state, and program level funding to local offices is primarily provided by county property taxes. County DFC office directors are responsible for the child welfare implementation functions in the respective counties, but child welfare policy is the responsibility of the Deputy Director of the Bureau for Family Preservation and Protection, also known as the Child Welfare Bureau, which includes Child Protection Services (CPS). The county office directors and deputy director of Child Welfare report directly to Director of the Family and Social Services Administration Division of Family and Children.

The deputy director of BFPP, though responsible for child welfare policy, has historically had limited authority over the DFC regions, local offices, or their employees, which implement child welfare policy. Instead, the six regional managers had line authority over the 92 local offices. Since 1999, BFPP deferred the reporting of child fatalities to the DFC Bureau of Program Integrity, a unit completely separate from either the child welfare policymaking or implementation arms of DFC. Its sole function is compiling data relevant to DFC operations and generating reports.

In Indiana, the Family & Social Services Administration, Division of Family & Children, and its predecessor agency, the State Department of Public Welfare, have collected information on the number of child fatalities due to abuse or neglect since 1980. Fatality information was collected via a manual system of reporting based on forms filed by local offices. The forms included the report of child abuse or neglect (form 310) and the investigation and findings (form 311). Information was conveyed to a particular staff member in the central office of the Division of Family & Children who compiled the information and provided consultation to local offices on these particularly difficult cases. In 1995-96, the Division of Family & Children piloted the Indiana Child Welfare Information System (ICWIS) and brought all 92 counties on line. The current child fatality information reporting system consists of both the manual method and the ICWIS computer based system. We discuss them separately.

The manual method entails a process in which local offices receive from various sources reports of child fatalities, enter that information into local tracking systems, and then convey that information to a designated person at the DFC central office BFPP. The manual process includes substantially greater information than that captured by ICWIS, such as autopsy reports, prosecutor's records, police reports, and hospital records, and was thought to be a more accurate system of tracking information. The counties do not use a uniform manual method of tracking or reporting child fatality information. On occasion, local offices have not reported fatality information in a timely fashion to central

office for numerous different reasons, including lack of notice of child fatalities, inaccurate or incomplete information about child fatalities, and simple failures to convey information among others. The central office employee designated to tally child fatality information often had to contact local offices to obtain child fatality information, but not all counties have been consistently responsive to such inquiries. This is so because county office employees believe the information sought by the central office employee is available in the computer based system, and because county employees have innumerable other demands upon them at a time when local offices are thought to be understaffed, under-funded, and under-trained. The Child Welfare League of America recommends a weighted caseload of 17 cases per worker, and Indiana's weighted caseload average is 27 as of October 2002. The manual information received by the central office is compiled and held by the designated employee until it is reviewed by an internal quality assurance review committee, which meets quarterly. However, child fatality cases were not always prepared for review at quarterly quality assurance reviews because the case files frequently contained incomplete information. That is, local offices had been unable to obtain coroner's reports, medical documentation, police reports, and other documents, and therefore could not forward information to central office. Historically, there have not been consistent statewide reports generated by local offices submitted to the DFC division director or deputy director, BFPP, neither of whom have had routine involvement in the manual reporting process.

Indiana's computer-based child welfare information system, or ICWIS, was designed by the private sector contractor Unisys under a contract with FSSA. Unisys operates and maintains ICWIS, but the state retains project management authority which allows FSSA personnel to oversee operation of the system. ICWIS can be accessed by employees of local offices and central office who have child welfare functions, and also by regional managers. In all components of ICWIS, client confidentiality and security of information have been of the highest priority. The system does not independently collate child welfare data from any sources, but instead produces reports based solely on the data put into the system by employees performing child welfare duties. Although some system modifications were made in the fourth quarter of calendar year 2002, ICWIS did not previously allow case managers in one county to view information entered by other counties, or different case managers in the same county to view information entered by other case managers in the county.

County office family case managers on the frontline are responsible for entering child fatality data into ICWIS, which they access via desktop computers. In the majority of cases, the information entered into ICWIS is received and recorded on paper tablets during field deployments and must be subsequently entered into the ICWIS system when the employee returns to the office. Although a pilot program exists to provide quick pad technology—a simple, portable word processing device—to county child welfare employees, most family case managers do not have portable technology that permits them to enter data into ICWIS while deployed. In addition, child welfare workers have described ICWIS as difficult to use because of its technical layout, including the large number of screens required to complete an ICWIS report, and limited information available on ICWIS.

Due to complicating factors, including budget constraints, hiring restrictions, confidentiality concerns, and federal regulatory issues, among others, local offices generally do not dedicate either temporary personnel or regular full- or part-time employees to the task of entering child fatality data into ICWIS or to manually reporting child fatality data to central office. Consequently, family case managers are often torn between their obligations to stay in the office to enter data into ICWIS, and getting into the community to provide protection services to children and families.

Policies were issued from the central office directing that child welfare information, including fatality data, should be entered into ICWIS, but for a variety of reasons compliance has been inconsistent over time. Although the policy did not specifically assign responsibility for ensuring that information was accurately entered into ICWIS in a timely fashion, that duty fell by default to county office supervisors and directors, then to regional managers, and then to the DFC division director in the course of their routine supervisory responsibilities. The deputy director, BFPP had limited authority, control, or supervision over regional managers, local directors, or county office employees performing child welfare duties. It is also fitting to note here that since the advent of ICWIS, there has been an increased emphasis on data collection, statistics, and reporting. The involvement of Federal authorities and a looming threat of financial sanctions influenced the use of ICWIS for a period, but that influence diminished when it was determined that Federal authorities could not financially penalize the states for failure to comply with SACWIS (ICWIS in Indiana) data standards. Neither regional managers, county office directors, nor county office employees have received routine reports or communications from central office regarding child fatalities, other than the annual fatality report.

The entry of accurate information into ICWIS and the capture of information by the manual procedure are affected by applicable child welfare policies and procedures, but substantive policies were not universally clear in Indiana, or in other states. While most child welfare professionals could agree that certain types of conduct represent abuse or neglect, they would not all agree that certain other types of conduct fall into that category. A striking example is the fact that most case managers would deem a murder of a child by his parent, guardian, or custodian a tragic crime, but not all child welfare professionals would find this a child fatality resulting from abuse or neglect. Some would identify this as a *criminal act* that resulted in a child fatality, which is something separate and distinct from *abuse or neglect* that resulted in a child fatality. Others would deem the violent act of murder to be the ultimate form of child abuse that resulted in a child fatality. This lack of definitional clarity is evidenced in cases where:

- Children are killed as a result of motor vehicle collisions in which the driver of the vehicle in which he was riding (his parent, guardian, or custodian) was intoxicated;
- Children are killed while riding unrestrained in motor vehicles subsequently involved in accidents.

In these and other instances, the decedent children may not be clearly identified as victims of abuse or neglect, and consequently, their deaths may not be captured in child fatality statistics. On the other hand, depending on the background, experience, and views of the case manager, county director, regional manager, or central office point of contact, children who die as a result of these types of occurrences *may* in fact be included in child fatality reports. Clearly, the child welfare professional's determinations on a particular case are influenced by education and training, cultural variations among communities, substantive policies in effect, interpretation and application of those policies, community tolerances, and other factors.

Additionally, the determination as to whether a child fatality resulted from abuse or neglect, and is thus captured in statewide statistics, may be affected by the substantive results of agencies and processes beyond the DFC. Investigations of child abuse and neglect, including those matters leading to death, may endure over many months, and in some cases span more than one calendar year. During that time, a DFC child protection investigation may reach conclusions at odds with those of criminal proceedings, autopsies, determinations of medical personnel, and other processes.

Alternatively, the child welfare investigation may not reach any conclusion pending the results of such other processes. This occurs because of cultural sensitivities, community tolerances, and other reasons. For example, a coroner investigating a child fatality in a small community, where most people know one another, may conclude the cause of death was "accidental" and therefore not investigate the deeper causes of the accident. The coroner, who is not required by law to have medical credentials or training in child protection practice, may apprehend no need for further investigation, or may view an intrusion into a grieving family's life as unwarranted under the circumstances. Even more, the coroner may have a basic difference of opinion with the child welfare worker as to whether an act leading to a child's death was neglectful. Consider an example where a young child dies while under the supervision of an older child. The child welfare worker or other reviewers may see the parents who left the older child to care for the deceased child as guilty of neglect for doing so, but the coroner, medical practitioner, or community members may find the parents' actions reasonable in that community. This has been seen in close-knit, religion-based communities in Indiana.

A similar quandary exists where the prosecutor concludes evidence is insufficient, or for other reasons within the prosecutor's discretion, that he will not prosecute a case of child neglect or abuse. Although the child welfare investigator may conclude the causative act was abusive or neglectful, the prosecutor may not charge the case because he cannot win a conviction and the case is otherwise a poor expenditure of limited resources. Particularly if no explanation of the prosecutor's reasoning is given or if it is not understood, the question then becomes who is right about the characterization of the conduct leading to a child fatality—child welfare investigator, law enforcement, prosecutor, coroner, or other entity—and whose determination controls whether the particular child fatality results from abuse or neglect and should thus be counted in statewide tallies.

Child welfare determinations have occasionally turned on the decisions of such entities outside the DFC, even where those decisions contravene the logical conclusions of child welfare practice. Child welfare workers often feel incapable or unqualified to second-guess the conclusions of law enforcement, medical, coroner, or prosecutorial personnel, and therefore give deference to their determinations.

Training for child welfare workers within the DFC could alleviate some dissonance between DFC conclusions and those of outside agencies, but obtaining training has been problematic. Appropriate training courses for child welfare workers are clearly available, but question exists as to its practical accessibility. The initial training course for child welfare workers is six weeks long, and is available at regional training sites around the state. Accordingly, child welfare workers needing to attend training must be away from their homes and families for lengthy periods of time, and pay out-of-pocket expenses for food and lodging. Although subsequently reimbursed for these expenses, they are still required to advance such expenses, which often imposes a difficult financial burden. In addition the state incurs mileage and other expenses for training travel, which is a difficult burden given the current fiscal environment.

Investigating child fatalities and severe abuse or neglect cases presents a special circumstance which severely affects child welfare case managers, and can thus influence the quality and quantity of information gathered and reported. Anecdotally, many child welfare workers are ill prepared and ill-equipped to conduct investigations of child abuse and neglect allegations where fatalities are involved. The process of investigating such allegations, particularly if the worker has had prior contact with the child, can exact an enormous toll on the worker's health and well-being. There currently exists no official method of helping child welfare workers handle the emotional toll of child fatality investigations. In addition, while larger counties like Marion, Allen, and Lake counties may suffer sufficient numbers of child fatalities that child welfare workers develop familiarity in conducting the subsequent investigations, smaller counties experience them so rarely that few if any of the workers in that county have any experience at all in investigating or reporting child fatalities. Both situations adversely impact the process of investigating and reporting child fatalities.

Best Practices Review

A thorough review of national literature and best practice approaches to preventing, assessing, and learning from child fatalities was an integral component of the work of the Child Fatality Reports Task Force. The Child Welfare League of America served as an invaluable resource in the review process.

Over the past decade, child fatalities due to maltreatment have increased at an alarming rate. The U.S. Advisory Board on Child Abuse and Neglect estimates that as many as 2,000 children die every year as a result of abuse and neglect. 75% to 80% of these fatalities annually were children five years and younger. In over 70% of these fatalities, the perpetrator was the child's parent, relative, or other designated caregiver. Of significant note, in Indiana, only this 70% of child fatalities would even be counted in

child fatality statistics, except for any resulting from sexual abuse. By Indiana statute, abuse and neglect can be designated only when that abuse or neglect is perpetrated by a child's parent, guardian, or custodian.

To address the need to prevent child fatalities, the U. S. Advisory Board on Child Abuse and Neglect made clear recommendations that are supported by the prevailing best practice literature. Those recommendations include the following:

1. Establish child fatality review teams at the local or regional level in each state;
2. Increase the availability of professionals qualified to identify child abuse and neglect fatalities;
3. Institute and enhance collaborative, multi-disciplinary training between all governmental and professional entities involved in the identification and investigation of serious and fatal child abuse and neglect;
4. In cases of fatal child abuse and neglect, states, jurisdictions, military branches and Indian nations should implement joint criminal investigation teams to ensure more effective reporting, learning, and prosecution;
5. The Secretary of Health and Human Services and the U.S. Attorney General should work together to assure ongoing national emphasis on fatal child abuse and neglect, and support a national system of local, state and federal child abuse and neglect review efforts.

The Legal Environment

The definition of child abuse or neglect is fundamental to the assessment of this Task Force and to the work of child welfare professionals throughout the community. However, the phrase "child abuse or neglect" is not statutorily articulated its own right, but is instead defined as a child alleged to be a child in need of services as described in the CHINS (Child in Need of Services) statute, save for alleged sexual abuse victims. See IC 31-32-11-1; IC 31-33; IC 31-34-7-4; IC 31-39-8-4; IC 31-9-2-14**;** IC 31-34-1-1 through IC 31-34-1-5, and; IC 35-42-4-3. Briefly, a child is a "child in need of services" if:

- The child's parent, guardian or custodian fails to provide the child with food, clothing, care, education or supervision;
- The parent, guardian or custodian's act/omission seriously endangers child's physical or mental health;
- The child is a victim of sexual abuse;
- The parent, guardian or custodian allows the child to perform in an obscene performance or commit sex offense, or;
- The child endangers his own or another's health.

Child abuse or neglect is not otherwise defined in Indiana or Federal statute. Thus, there is considerable room for the exercise of discretion by the particular evaluator in determining whether a given act constitutes child abuse or neglect. In practice, there is no uniform understanding amongst and between members of the public, media, law

enforcement, judicial, and child welfare professionals as to duties, obligations, and definitions of relevant child welfare and child protection terms.

Accurate statewide child fatality information is affected by reports of child abuse or neglect from various community sources to the DFC. More particularly, the accuracy of information is adversely affected by information that does *not* reach the DFC. Most members of the community are likely aware that certain people such as teachers, doctors, and others in special positions of trust and authority have an affirmative duty to report suspected child abuse or neglect. See IC 31-33-5-2. However, it does not appear generally known that reporting child abuse and neglect is a legal obligation of *all* members of the community. See IC 31-33-5-1. The Task Force found at least one instance in which a judge and a prosecutor were purportedly unaware of an affirmative duty of all people to report suspected child abuse and neglect. In addition, although statute clearly sets forth the duties and obligations of various people in the community to cooperate in investigations and subsequent reporting, testimony indicates that some official and entities occasionally fail to do so.

It is also appropriate to note that legal and other interests of diverse groups may affect the delivery of child welfare and protection services, and related reporting in Indiana. For example, multiple anecdotal accounts of dispositions of some DFC employment grievances or legal actions have resulted in the actual or threatened return to duty in child welfare positions of employees who have been disciplined for reasons that may include poor job performance. Likewise, state and federal regulatory and statutory mandates or proscriptions determine the length of time information can be retained in the child welfare information system and who may have access to the information. While certain elements of those guidelines likely have merit, it is not altogether clear that all such guidelines promote the best interests of child welfare practice or reporting child fatality statistics.

Findings

The Task Force finds the following factors contributed to the inaccurate reporting of child fatality statistics for the covered period:

- Issues both within and outside the agency's control have contributed to the advent of these factors.
- Vague or ambiguous child welfare definitions and policies, starting with the absence of a uniform definition of child abuse and neglect;
- Unclear lines of authority, and undefined relationships between DFC central office personnel/bureaus and local Offices of Family and Children;
- Inconsistent compliance by DFC employees with expressed policies and procedures;
- Understaffed or inappropriately staffed child welfare units, in concert with the inability of local directors to apply human resources to meet ICWIS data entry requirements;

- Difficulty in accessing training for child welfare workers due to limited time and money, and workloads that do not easily allows workers to participate in extensive training;
- Inadequate communication and collaboration between the agency and outside medical, criminal justice, health, and other key authorities.

Recommendations In Detail

In light of the foregoing, the Child Fatality Reports Task Force makes the following recommendations.

Comprehensive Recommendations Relating to Both Internal and External Factors

1. **Initiate and support appropriate legislative, regulatory, and management actions to ensure the interests of the children involved in the CPS system are first priority among all other interests, including employee grievances and union settlements regarding the placement and qualification of child welfare workers.**

2. **Review, support, and follow through on feasible recommendations of the Child Fatality Review Task Force in its report titled "Keeping Kids Alive: Recommendations for Implementing a Statewide Systematic Review of Childhood Deaths" (April 2000).** Particular focus should be given to training, data collection, child fatality review teams (outside the agency), and public awareness. See Appendix B.

3. **Seek expanded funding from all available sources to develop and focus expertise in child fatality prevention**. Providing the fullest possible protection for Indiana's children requires that maximum combined funding from federal, state, county, and private monetary resources be employed efficiently with other community resources and assets to create and sustain the high quality child protection system Indiana's children deserve.

4. **Support legislation enacting a Commission on Abused and Neglected Children and Their Families (SB62).** The Task Force recommends the Commission be enacted and appointed to address issues beyond our scope. Among these issues are:

    - The need for a clear and consistent definition of child abuse and neglect in Indiana statute;
    - A review of child protection and child welfare caseload sizes;
    - A study to determine whether the "indicated" case status should be added to the "substantiated" and "unsubstantiated" statuses;
    - The need for improved collaboration among medical, criminal justice, health, elected officials, and other key authorities in child protection;
    - Services to prevent child abuse and neglect;
    - Funding for child protection, and abuse and neglect programs, and;

- Accessibility and variety of multi-disciplinary training for those involved in child protection.

Recommendations Related to Internal Factors to Improve Reporting of Information Within the Agency's Knowledge

5. **Promote maximum accountability of those responsible for child welfare and child protection for fully and properly executing their duties**. DFC managers must be fully empowered and required to make those with child welfare and protection responsibilities liable for the consequences of their actions or inaction in accordance with appropriate performance standards. This requires DFC to establish and adhere to employment practices and professional standards of conduct for those involved in child welfare and child fatality reporting which provide for zero tolerance of malfeasance or nonfeasance. Child protection services and accurate reporting must be consistently recognized and supported as priorities. All other competing interests must be reasonably relegated to positions of lesser priority vis-à-vis the interests of child protection and accurate reporting of child fatality information.

6. **Employ ICWIS as the sole official system for the DFC's child welfare information**. Manual tracking and reporting child fatality information should be relied upon only for emergency notification and media awareness, and as a back-up for the computer-based ICWIS system. DFC management at all levels should consistently ensure that employees faithfully comply with clear policies and procedures established to track and report accurate child fatality information.

7. **Modify ICWIS system capabilities**. The system should be redesigned to make it easier for child welfare workers to use. Making ICWIS more user friendly will likely increase the probability that DFC employees tasked with using it will in fact do so, and decrease the need for supervisory personnel to coerce its use or penalize the failure to use it. DFC child fatality reports should be modified to include additional and more useful information, and incorporated into the ICWIS system.

8. **Enhance systems for data entry by increasing the use of technology in the field and use dedicated or temporary personnel for data entry purposes.** If the DFC's current pilot program to provide quick pads to field staff proves beneficial and cost-effective, such technology should be made uniformly available to the field staff in order to reduce the duplicative effort required to put data into the ICWIS system. This will increase efficiency by eliminating duplicative efforts, particularly in light of current budgetary and personnel concerns. If quick pads prove ineffective, other new technology such as portable computers should be considered. Additionally, DFC should re-examine the distribution in the counties of existing technology like cell phones, scanners, and micro-recorders as necessary to assure that all local offices across the state have necessary technology to meet their reasonable

professional obligations and security concerns. Additionally, using dedicated clerical personnel—including temporary or contract personnel as appropriate—for data entry purposes will free highly trained case managers to perform the actual frontline work of protecting children, knowing their whereabouts, and investigating/reporting child abuse and neglect allegations, and child fatality information.

9. **Release fatality information at a specified time each year, with an advisory that figures may require adjustment for reopening of cases where children die after abuse or neglect is substantiated**. This measure will foster a predictable time each year when the public can expect accurate fatality information from FSSA-DFC, and predictable times for the agency to begin and stop counting child fatalities for inclusion in the annual report. At the same time, consumers of the fatality report will understand that a possibility exists that numbers may be adjusted if the death of a child is subsequently determined to be a result of abuse or neglect according to clearly defined child welfare policies. Official fatality statistics should consistently reflect the date of death as the benchmark date for reporting purposes.

10. **Strengthen and clarify the role of the central office BFPP, which makes child welfare policy, relative to the local offices of family and children, which implement policy**. The necessary structure of DFC separates the central office BFPP, which makes child welfare policy, and the local Offices of Family and Children, which implement policy. DFC management should make clear the responsibility and authority of the BFPP for making and monitoring child welfare, protection, and reporting policies, and of the county directors and regional managers for implementing and enforcing those policies. The DFC Director should ultimately ensure compliance with proper policy, resolve any conflicts, and hold all parties accountable for properly executing their duties. Establishing clarity about the inter-relationship and authority of local offices and the BFPP will assure efficient interactions on important issues and alleviate problems caused by ambiguities or vagueness.

11. **Clarify relevant child welfare policies and procedures**. Child welfare policies in Indiana, as in other states, have been subject to wide interpretation and debate. Whether "right" or "wrong" according to the various standards that will be applied to the issues, DFC must establish decisive policies about the meanings of terms and definitions of critical child welfare terms, including but not limited to *probable cause*, *investigatible death*, *abuse and neglect*, and others. Similarly, DFC must establish uniform procedures for how local offices and central office handle the many issues associated with child welfare practice. Issues falling into this category include determining what agency is responsible for deciding whether a child fatality was the result of abuse or neglect; what times, events, and dates to use for reporting purposes; and other issues. DFC should ultimately be responsible for deciding these issues for purposes of agency practice and reporting. It should consult with appropriate stakeholders, including the medical community, prosecutors, coroners, law enforcement officials, the judicial community, and its own frontline case

managers, to name a few. The purpose of DFC internal quality assurance fatality review committee should be reviewed and clearly defined.

12. **DFC should enact specific monitoring requirements at local, regional, and central office levels**. Child fatalities should be reviewed weekly at local offices of family and children, monthly at regional management meetings, and quarterly at the central office level. Consistent reviews of child fatality information at the local, regional, and state levels will provide a heightened focus on accurate child fatality reporting, and provide an opportunity for more frequent and earlier alerts to adverse trending in the various regions of the state. It will also help identify reporting issues before they are too complex or removed in time.

13. **Continue to improve child welfare training with substantial focus on the quality of information gathered and reported, management training, and substantive skills.** Child welfare training in Indiana appears to be of high quality and substantial use. However, the results of our inquiry indicate that several very pragmatic impediments exist to accessing that training. Funding for child welfare training and workload constraints are substantial obstacles in terms of when and where courses are offered, when workers can attend training, and how expenses associated with attending training are paid. DFC must increase the accessibility of training to child welfare workers in terms of release time, while still meeting its 24 hours per day, 7 days per week obligation to provide child protection services as required by statute.

14. **The DFC should establish regional bodies of expertise in child fatality investigations**. Testimony of various sources consulted by the Task Force suggests that lack of expertise among some child welfare workers due to the infrequency with which they confront child fatalities may adversely affect the investigation of relevant cases and accurate reporting of that information to designated sources. At the same time, it may not be cost effective to provide in-depth training on child fatality investigations to all child welfare workers. Accordingly, each DFC region should develop cadres of child protection workers with specialized training in child fatality investigations to consult with and support local office workers in their regions on various cases that present. Developing core expertise and making it uniformly available across the 92 counties will improve the accuracy and timeliness of child fatality information reporting. It will also create a framework for providing support to child welfare workers. DFC should provide mental health support for case managers involved in child fatality investigations.

15. **DFC should examine its policies and practices regarding the release of child fatality information to ensure the widest possible disclosure within the bounds of state and federal law**. The DFC has occasionally been criticized and censured for failing to release information pertaining to issues of child welfare, and in particular child fatalities, but at the same time is proscribed by law from releasing much of this information without proper consent. To avoid the appearance of hiding information, the DFC should ensure its stated policies and actual practices promote

the release of information to the public, advocates, legislators, and others to the extent permissible by law.

Recommendations Related to External Factors to Improving Reporting of Information to the Agency to be Included in Statewide Tallies

16. **Promote greater public involvement in child protection and child fatality reporting**. The state should continue its current practice of designating a month for child abuse and neglect prevention to heighten media and public attention on preventing child abuse and neglect as the ultimate means of reducing the number of child fatalities that occur and must be reported. An annual meeting of state agencies and others interested stakeholders should be convened to review of the causes of child fatalities and formulate a public education message, targeted at reducing the risks for child fatalities. The state should provide the media with continuing awareness of effective prevention strategies and programs, and suggestions on highlighting prevention mechanisms along with related features of abuse and neglect cases.

17. **Identify a lead state agency to tabulate and report all child fatalities, and establish systems interfaces between ICWIS and State Board of Health information systems**. This measure would help assure that all fatalities of Indiana residents younger than 18 years of age are reported to the agency which can then reconcile that information with reported child fatalities, thus helping ensure accurate annual fatality reports.

18. **Encourage medical, criminal justice, health, and other key authorities outside DFC to establish and support training, best practices, and conduct standards for their staffs which provide for zero tolerance of malfeasance or nonfeasance, and to fully meet their statutory obligations.**

Recommendation Summary

Although this Task Force has made numerous and broad recommendations for change, several are of immediate priority. By January 28, 2003, DFC management should develop an implementation plan for the following core recommendations:

1. Promote maximum accountability of child welfare and child protection workers.
2. Employ ICWIS as the sole official system for agency child welfare information.
3. Modify ICWIS system capabilities.
4. Increase the use of technology in the field and use dedicated personnel for data entry.
5. Strengthen and clarify the role of the central office BFPP relative to local offices.
6. Clarify relevant child welfare policies and procedures.
7. Enact specific child fatality monitoring requirements.
8. Establish regional bodies of expertise in child fatality investigations.

[end of report]

This report of the FSSA Child Fatality Reports Task Force is respectfully submitted this 17th day of January 2003:

Michael Murray	Sharon Pierce	Cathy Graham
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Appendix A: Applicable Legal Authorities.

IC 31-9-2-14: "Child abuse or neglect." Sec. 14. (a) "Child abuse or neglect", for purposes of IC 31-32-11-1, IC 31-33, IC 31-34-7-4, and IC 31-39-8-4, refers to a child who is alleged to be a child in need of services as described in IC 31-34-1-1 through IC 31-34-1-5. (b) The term does not include a child who is alleged to be a child in need of services if the child is alleged to be a victim of a sexual offense under IC 35-42-4-3 unless the alleged offense under IC 35-42-4-3 involves the fondling or touching of the buttocks, genitals, or female breasts. *As added by P.L.1-1997, SEC.1.*

IC 12-13-15: Creates the Child Fatality Review Board, allows local review boards to be created, requires the collection of data on child fatalities and requires the division to make an annual report.

IC 12-14-25.5-1 (Family Preservation Services): Requires DFC to provide intervention other services to protect the children and maintain the family.

IC 31-32-11-1: Prevents privilege as a grounds to exclude evidence of abuse in testimony from between a husband and wife; health care provider; certified social worker or certified clinical social worker; certified marriage or family therapist and a patient; school counselor or school psychologist and a student. Since there is no privilege, the duty of all people to report abuse/neglect supersedes what might have otherwise been considered privileged and, thereforee, free from the duty to report abuse.

IC 31-33-2-4: Creates and sets out the duties of local child protection services. The following chapters create child protection teams and set out information sharing and cooperation requirements.

IC 31-33-5-1: Creates the duty for ***ANY*** person who has "reason to believe" to report abuse. It states, "In addition to any other duty to report arising under this article, an individual who has reason to believe that a child is a victim of child abuse or neglect shall make a report as required by this article."

IC 31-33-5-2: states that any person required to make a child abuse/neglect report in his capacity as a member of the staff of a medical, private, public institution, school, facility or agency shall immediately notify the individual in charge of the institution, etc. (Does not relieve the person of the duty set out in IC 31-33-5-1 pursuant to IC 31-33-5-3).

IC 31-3-6-1: Establishes immunity from liability for good faith reporting of child abuse or neglect.

IC 31-33-6-3: Establishes the presumption of good faith in reporting.

IC 31-3-7-1 through 3: Establishes the requirements for CPS to accept abuse reports 24 hours a day, 7 days a week, and via telephone and hotline.

IC 31-33-7-5 through 6: Establishes the requirement for CPS to make a written report of abuse /neglect and to share reports with prosecuting attorneys and law enforcement, including the coroner.

IC 31-33-7-6: Requires the coroner to investigate and report findings to CPS, prosecuting attorney, law enforcement as well as any hospital that initially reported the matter to the coroner.

IC 31-22-7-7: Requires law enforcement to immediately report it to CPS and conduct an immediate on site joint investigation with CPS if law enforcement has a reason to believe that an offense has been committed. In all cases, law enforcement must forward any information to prosecutor and juvenile court.

IC 31-33-7-8: Requires CPS to make reports back to health care providers or entities and schools that initiated cases.

IC 31-33-8: Discusses child abuse investigations and duties of law enforcement and medical providers to cooperate.

IC 31-33-9: Discusses DFC's ability to hire private agencies to investigate and covers investigations for children under the care of private or public institutions.

IC 31-33-10: Requires doctors to photograph or x-ray visible trauma.

IC 31-33-11-1: Discusses the release of abused children from the hospital into the custody of the patient's parent or guardian and related documentation.

IC 31-33-12: Discusses offering of services to family following investigation.

IC 31-33-17: Creates the child abuse registry.

IC 31-33-22: Discusses liability for failure to report and for making false reports.

Appendix B: **"Keeping Kids Alive: Recommendations for Implementing a Statewide Systematic Review of Childhood Deaths" (April 2000)**

ATTACHED

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